# IN THE UNITED STATES DISTRICT COURT FOR THE D MIDDLE DISTRICT OF ALABAMA NORTHERN DISTRICT 2006 OCT 10 A 10: 55

JAMES G. HUFFMAN,

Plaintiff,

**CIVIL ACTION NO. 2:06-CV-748-MEF** VS.

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(WO)

SOUTHERN HEALTH SERVICES PARTNERS, AUTAUGA COUNTY METRO JAIL, SHERIFF HERBIE JOHNSON, LARRY NIXON AND DR. NICHOLSON, M.D.

Defendants.

## REPORT BY DEFENDANTS, AUTAUGA COUNTY METRO JAIL, **SHERIFF HERBIE JOHNSON and LARRY NIXON TO ABOVE-STYLED ACTION**

COMES NOW the Defendants, AUTAUGA COUNTY METRO JAIL, SHERIFF HERBIE JOHNSON and LARRY NIXON, in the above-styled cause and after a review of the subject matter of the Complaint provides to this Honorable Court a report as requested by Order dated the 30th day of August, 2006.

#### A. FACTS AND CIRCUMSTANCES

The Plaintiff, JAMES G. HUFFMAN, was incarcerated in the Autauga County Metro Jail from September 13, 2005 until February 6, 2006 and from April 30, 2006 to the present date.

The Plaintiff's complaint revolves around the following items:

- 1. Medical Conditions not being adequately treated through a denial of medication.
- 2. Southern Health Partners' failure to provide their corporate address.
- Southern Health Partners' failure to provide the name and address of its President 3. and Board of Directors.
- Southern Health Partners' failure to provide the names of the nurses employed by 4. them.



See attached statements of Sheriff James Johnson and Deputy Sheriff Larry Nixon attached hereto as Exhibits "A" and "B" and made a part hereof and which provides a summary of the facts and circumstances surrounding this matter.

#### **B. CORRECTIVE ACTION BY PRISON OFFICIALS**

The Autauga County Sheriff's Office does not see a need to take any corrective action since it feels that its present policies and procedures dealing with inmate medical treatment is appropriate. Since the items directly concerning Southern Health Partners do not address any items to the Defendants herein, no further statements will be made concerning same.

#### C. OTHER COMPLAINTS

The other complaints known to the Defendants deal with a Complaint pending in this Court by the following individual:

Thomas Andrew Hollis v. Nurse Tina Ellis, et al under Civil Action No. 2:06-CV-814-WKW dealing with medical treatment. This case is in the beginning stages of response.

The allegations in the Complaint appears to be similar enough to warrant consolidation of the claims if this Court so orders.

DATED: October 9, 2006

ROBERT FAULK (FAU002)
Attorney for Defendants

OF COUNSEL:

McDOWELL, FAULK & McDOWELL, L.L.C.

Attorneys at Law

145 West Main Street

Prattville, AL 36067

(334) 365-5924

Telephone

(334) 365-6016

Facsimile

robert@mcdowellfaulk.com

## **CERTIFICATE OF SERVICE**

I hereby certify that I have on the 9th day of October, 2006 served a copy of the foregoing on Mr. James G. Huffman by hand delivery to the Autauga County Metro Jail and address as follows:

Mr. James G. Huffman Autauga County Metro Jail Autauga County Courthouse Prattville, AL 36067

J. KOBERT FAULK

# **EXHIBIT A**

#### EXHIBIT "A"

STATE OF ALABAMA

**COUNTY OF AUTAUGA** 

#### AFFIDAVIT OF SHERIFF JAMES JOHNSON

BEFORE ME, the undersigned, a Notary Public in and for said County and State personally appeared JAMES JOHNSON, whose name is signed to the Affidavit and who is known to me and who being by me first duly sworn, doth depose and say as follows:

My name is JAMES JOHNSON and I am the Sheriff of Autauga County, Alabama. I have been the Sheriff for fifteen and one-half  $(15 \frac{1}{2})$  years.

The purpose of this Affidavit is to provide to this Honorable Court the facts and circumstances surrounding a Complaint filed in this Court by JAMES G. HUFFMAN by Civil Action No. 2:06-CV-748-MEF.

James G. Huffman is currently an inmate in the Autauga County Metro Jail and his dates of incarceration were September 13, 2005 to February 6, 2006 and from April 30, 2006 until the present. He files this Complaint with this Honorable Court alleging inadequate medical treatment by the Autauga Metro Jail, Sheriff James Johnson and Deputy Larry Nixon. He also alleges inadequate medical care against Southern Health Partners and Dr. Kenneth Nicholson (actually Nichols), M.D. Furthermore, he alleges that Southern Health Partners refuses to supply him with requested information concerning their employees and corporate structure.

Since the only complaint against myself and the Autauga County Metro Jail is an allegation concerning inadequate medical treatment, I will address only that item. It is true that the inmate has some health problems which includes a heart condition. As such, I am enclosing copies of Mr. Huffman's medical files which are attached hereto as Composite Exhibit "C" and made a part hereof and which contain the following records:

- 1. Order of Commitment.
- 2. Initial Inmate Assessment
- 3. Prattville Fire/EMS Report
- 4. Prescriptive drug records.
- 5. Progress notes.
- 6. Refusal of Treatment and Release of Responsibility
- 7. Medication Administration Records
- 8. Radiology Report
- 9. Inmate Sick Call Slips
- 10. Hospital records from Baptist Health
- 11. Admission Data/History and Physical Form

Our jail is a narcotic free facility. This means that when an inmate is housed in our jail and was previously on a narcotic prescription, Dr. Kenneth Nichols, jail physician, will substitute a non-narcotic medication for the narcotic mediation. (For example, Plavix is equivalent to ASA which is nearly equivalent to aspirin to prevent blood clots in heart patients.) Apparently, Mr. Huffman is complaining because he is not receiving his "brand name" prescriptions. However, as is evident from the Medication Administration Records attached hereto, Mr. Huffman is receiving substantial amounts of medication as prescribed by Dr. Nichols.

In addition to the above and as further explanation, inmates are provided medical care by Dr. Nichols and administered by Southern Health Partners. They fill out a doctor's slip and the inmate is treated either by a nurse provided by Southern Health Partners or by Dr. Nichols, as the case may be. Dental care is provide by Dr. J. Ronald Roberson under the same conditions as medical care is

provided by Dr. Nichols.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this the 9th day of October, 2006.

Sheriff

Autauga County, Alabama

SWORN TO and SUBSCRIBED before me on this the 9th day of October, 2006.

LMy Commission Expires: J. ROBERT FAULK

A Notary Public of Alabama My Commission Expires August 11, 2007

> J. ROBERT FAULK A Notary Public of Alabama My Commission Expires August 11, 2007

# **EXHIBIT B**

EXHIBIT "B"

STATE OF ALABAMA

**COUNTY OF AUTAUGA** 

#### **AFFIDAVIT OF DEPUTY SHERIFF LARRY NIXON**

BEFORE ME, the undersigned, a Notary Public in and for said County and State personally appeared LARRY NIXON, whose name is signed to this Affidavit and who is known to me and who being by me first duly sworn, doth depose and say as follows:

My name is LARRY NIXON and I am a Deputy Sheriff for Autauga County, Alabama. I have been a Deputy Sheriff for 12 years. I am also the Chief Jailer for the Autauga County Metro Jail.

I have read the Affidavit of Sheriff Johnson and concur in his report and to the accuracy thereof.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this the 9<sup>th</sup> day of October, 2006.

LARRY MIXON

Chief Jail

Autauga County Metro Jail Autauga County, Alabama

SWORN TO and SUBSCRIBED before me this the 9th day of October, 2006.

My Commission Expires:

J. ROBERT FAULK
A Notary Public of Alabama
My Commission Expires August 11, 2007

# **EXHIBIT**

C

# ORDER OF COMMITMENT/RELEASE FORM

# IN THE CIRCUIT COURT OF AUTAUGA COUNTY, ALABAMA

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## TO THE JAILER OF AUTAUGA COUNTY

STATE OF	ALABAMA	V.	James	7	Huffmar	`
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#### Case 2:06-cv-00748-MEF-WC Document 17-4 Filed 10/10/2006 Page 3 of 57

09/13/05 19:33

AUTAUGA COUNTY METRO JAIL Initial Inmate Assessment:

562 Page:

Booking Number:

33089

Confined - No loc

Active

Name Number:

76393

JAMES GRANT HUFFMAN

Added By: 562

Modified By: 562

Added When: 19:30:20 09/13/05 Modified When: 19:33:13 09/13/05

(See below)

#### Assessment Text:

Part One: Answer each question based on your observation of the inmate:

1. Is the inmate disoriented, confused, or unconscious?

2. Does the inmate complain of pain?

y chest pains medics was called to this situation

3. Does the inmate have visible trauma or bleeding?

n 4. Are there visible signs of alcohol or drug influence?

n

5. Are there visible signs of withdrawal from alcohol or drugs?

n

6. Is there evidence of swelling, infection, or skin marks?

n

7. Is there evidence of vermin or jaundice?

n

- 8. Does the inmate carry medications or report being on medications? ves
- 9. Is behavior suggestive of assault risk for staff or other inmates?

n

10. Is the inmate's behavior violent or aggressive?

11. Do the inmate's wrists have any scars?

- 12. Describe special measures you have taken for this inmate:
- called medics to have him checked medics said he was ok see reports

# Case 2:06-cv-00748-MEF-WC Document 17-4 Filed 10/10/2006 Page 4 of 57 $Prattville \ Fire/EMS$

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# **HIPAA Privacy Policy Notice**

THIS NOTICE DESCRIBES OUR PRIVACY POLICY, DESCRIBES YOUR RIGHTS, AND DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED TO OTHERS. PLEASE REVIEW IF CAREFULLY. YOUR HEALTH AND YOUR PRIVACY ARE OUR CONCERNS.

Prattville Fire & Ambulance wished to inform you of your rights regarding your private health care information. You have the right to review our Privacy Policy prior to signing the consent. By signing our consent, you acknowledge that your have had the opportunity to review our Privacy Policy. In the event that our policy changes and you want a revised copy, please contact us at 102 West Main Street, Prattville, AL 36067.

You also have the right to request that we restrict the method in which we use or disclose your health information for purposes of treatment, payment, or other health care operations. We have the right to refuse to comply with your request.

By signing the consent, you expressly acknowledge our use and disclosure of your health information for purposes of treatment, payment, or other health care operations. This notice will not expire and will apply to services provided to you from this day forward.

We will keep and record information about your medical condition. We may use this information or disclose this information to others as follows:

We may use or disclose your health information in order to treat you. For example, we may advise the health care provider which we are transporting you to of your medical condition, including your vital signs and medication we have administered to you. We may also disclose your condition to family or care-givers who are involved in your medical care.

We may use or disclose your health information in order to receive payment for the services we provide to you. For example, we may disclose your condition in order for your insurance company to understand why you received treatment so that they will pay your claim. We may also disclose your information to our billing department/ billing company/ attorney in order to seek payment for the services we provide to you.

We may use or disclose your health information for our operations. For example, we may review your information in order to evaluate your treatment and our services in order to insure that our care for you and in the future is the best that it can be. We may use your health information to contact you in the future. We may also disclose your information as required by law.

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Southern Health Partners, l.

Confidential

# Refusal of Treatment and Release of Responsibility

I am refusing any and all medical procedures and/or treatments of my current medical condition. If I decide to obtain medical treatment regarding my current condition, I we notify the medical staff immediately. I understand the limitations of treatment that means been based on my refusal of prior treatment.  Therefore, I release Southern Health Partners, Inc., its staff, the facility and its staff are administrator(s) from all responsibility and I assume personal responsibility for the		Inmate's Name: James Huffman
This is to certify that I, James Huffman currently in custody at the Autaua Connecto Jail  I have been told about the risks of refusing treatment for my current medical condition and acknowledge that I understand all medical information, current diagnosis, a future procedures that have been explained to me.  I am refusing any and all medical procedures and/or treatments of my current medical condition. If I decide to obtain medical treatment regarding my current condition, I we notify the medical staff immediately. I understand the limitations of treatment that medical based on my refusal of prior treatment.  Therefore, I release Southern Health Partners, Inc., its staff, the facility and its staff and administrator(s) from all responsibility and I assume personal responsibility for the conditions that may occur as a result of my refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.  Fun New York has a conformation of Inmate Signature of		Date of Birth: 10-29-53 Social Security No.: 418-78-9424
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condition. If I decide to obtain medical treatment regarding my current condition, I we notify the medical staff immediately. I understand the limitations of treatment that me have been based on my refusal of prior treatment.  Therefore, I release Southern Health Partners, Inc., its staff, the facility and its staff are administrator(s) from all responsibility and I assume personal responsibility for the conditions that may occur as a result of my refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.  Tam New York has an O9/02/06  Signature of Inmate  9-2-06		I have been told about the risks of refusing treatment for my current medical condition and acknowledge that I understand all medical information, current diagnosis, and future procedures that have been explained to me.
administrator(s) from all responsibility and I assume personal responsibility for the conditions that may occur as a result of my refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.  Jan Nefusing from this data on 09/02/06  Signature of Inmate  9-2-06	·	I am refusing any and all medical procedures and/or treatments of my current medical condition. If I decide to obtain medical treatment regarding my current condition, I will notify the medical staff immediately. I understand the limitations of treatment that may have been based on my refusal of prior treatment.
Signature of Inmate  Signature of SHP Medical Representative  9-2-06	Tax	Therefore, I release Southern Health Partners, Inc., its staff, the facility and its staff and administrator(s) from all responsibility and I assume personal responsibility for the conditions that may occur as a result of my refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.
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CC: Confidential Medical File Jail Administrator

Elnmate has requested we stop all of this meds 3712 Ringgold Road, #364
Weept Vistaril, Elaril, Aspirim because he Chattanooga, TN 37412
423-553-5635 Phone
is unable to pay for all of it. JE, MTA

## **PROGRESS NOTES**

DATE		NOTES SH	OULD BE SIGNED BY PHYSICIAN	ı	
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	Doctor's Sign	ature:		<del>.</del>	<u>-</u>
NAME-Last	First Mi	ddle	Attending Physician	Record No.	Room/Bed

# Physician's Orders

Southern Health Partner's, Inc.

Inmate Name: Hands Self: 10-29-53 Allergies: NLA	Juan, James	Facility: <u>Hufaus a</u> County Jail
L		

Date: 9/21/06	Date:
Thursofen 800 b	id x 10 days prn,
Flexeril 10mg	id x 10 days prn, bid x 5 days
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M.D. Sig	M.D. Sig:
Date:	Date:
M.D. Sig	M.D. Sig:

## Southern Health Partners

# MASTER PROBLEM LIST

For Use with Chronic Condition Patients. Chronic Conditions are classified as (but not limited to): Diabetes (IDDM/NIDDM), Hypertension, Pregnancy, HIV/AIDS, Asthma, Seizures, Diagnosed Mental Illness, CHF, Hepatitis.

Date Problem Identified/Dx	Chronic Condition	M.D. Comments	Date Of Initial M.D. Eval	M.D. Initial
11/1/05	H714			N
11/1/05	Depression			W
			·	
	v			

MEDICATION ADMINISTRATIC. RECORD

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THROUGH 9- 31-06	
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. Physician Alt. Telephone	
Rehabilitative Potential	
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agnosis:	
Medicaid Number Approved By Doctor:	$\dashv$
By: Title: Date:	
RESIDENT HURANGE COME D.O.B. 10/29/53 Sex Room 6 Patient Admission Date	

Document 17-4

Filed 10/10/2006

Page 14 of 57

AUTAUGA COUNTY JAIL HUFFMAN, JAMES

Title:

Patient

Code

Room

#

Date:

Admission

REPORT DATE: 09/06

MEDICATION ADMINISTRATIC. RECORD

pg. 102

By:

RESIDENT

HITTEMAN

D.O.B.

# SOUTHERN RADIOLOGY SERVICES, LLC X-RAY REPORT

DATE

LAST NAME

FIRST NAME

М

7/5/2006 D.O.B. HUFFMAN SEX JAMES

FACILITY

X-RAY NO.

CHEAL

SHP-AUTAUGA CO JAIL

ORDERING PHYSICIAN

NICHOLS

**LEFT ANKLE, TWO VIEWS, 07/05/06**: Anterior tibial and dorsalis pedis artery calcifications are present. No fracture, dislocation or any significant bony abnormality identified.

## \*DICTATED BUT NOT REVIEWED\*

Randall Finley, M.D./pag

tt: 7/5/2006 1:53:24 PM td: 7/5/2006 1:41:33 PM

PHYSICIAN'S SIGNATURE:	NURSE'S SIGNATURE: O. FILE MTA	X-RAY #	теон: <u>ИД</u> И.Т
Because of physical psychological and/or age limitations, this patient would find it difficult to receive this/these procedure(s) at a fixed site. I certify that	ORDERING CODE	DATE: 7) 5 (1)	#VIEWS:
this/these procedure(s) is/are medically necessary for the proper treatment of this patient.	PHONE #: ( )	ARRIVE TIME: 930/1/s	Q0092 # /
RADIOLOGIST:	FAX: ( )	DEPART TIME: 9554	# PTS SEEN /
PRELIMINARY REPORT:			
			AM



# **INMATE SICK CALL SLIP - MEDICAL REQUEST**

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: <u>08/29/06</u>	Pod/Location	1: <u>10P0d</u>	Cell:_ <i></i>	) <i>1</i>	#
Inmate's Full Name:	ies G.	HUFFMA	W		
Complaint/Problem: PUL	sse dro	palln	w medi	cations	- alxeept
Mu apoirin,	clavil c	and lis	taril (88)	due to t	he lact &
My Ouping Cant afford	to pay	brit be	Calle	I the #	102.00 debt,
How long have you had this pro	oblem?				
Inmate's Signature:	20 P.Hu	lfman		Date:	1911st 28,200
*****	******	* ******		*** *****	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
TO BE COMPLETED I	V MEDICA	I STACE.			
Note Patient's Vital Signs:	Temp	Resp	Pulse	B/P	Processing and the second seco
Instructions/Assessment: Doc	ument your findi	ings, Inmate's r	esponses/action	S	
•					
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				<del> </del>	<del></del>
	-			~	
<del></del>	<del></del>				
☐ Received Orders – thru Trea		•	order; via verba	al order	
☐ Follow-Up Required? If che ☐ Chronic Condition	ckeu, date to be	e seen ayaın			
☐ Inmate to be charged throug	h medical co-pa	ay for this visit			
Date Seen by Medical:	See	n by:			
Place original form in patient's medica		ţ			
* that occur	med di	uba	mixtur	o in the	medication
* that occur listing of or	dered.	meda	not how	ing been	sent to



# 3rd sick call request about andle OTYONOG NEEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Scix Call Slip and return it to the correctional officer and/or medical staff for subsection and review by the medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 07/04/06 Pod ocasion: 5 Cell	507 st 76363
Inmate's Full Name: TAMES 6. HUFFMAN	<u> </u>
Complaint/Problem: My andle on the left log is Dute Weight on it decause of the Jewise pain who my back is hutting that badly of the Dans in 3 pool by Robert Wille low long have you in spool of Sino June 26, 200 Deans in 3 pool of Dans in 3 pool	iner I was purhed down
******* ******** ******** ***	Da 06/01/06
O BE COMPLETED BY MEDICAL STAFF:  ote Patient's Vital See Perso Pulse	Ordered X-neux TB
structions/Assessment accument your lakings, inmate's responses/ac	
Received Orders – East Treatment Protocols; via teleptore order; via ve	abel order
Shrenic Condition	
nmate to be charged abough medical co-pay for this visit	
⇒ Seen by Medical Seen by:	
eriginal form in paties a medical record	

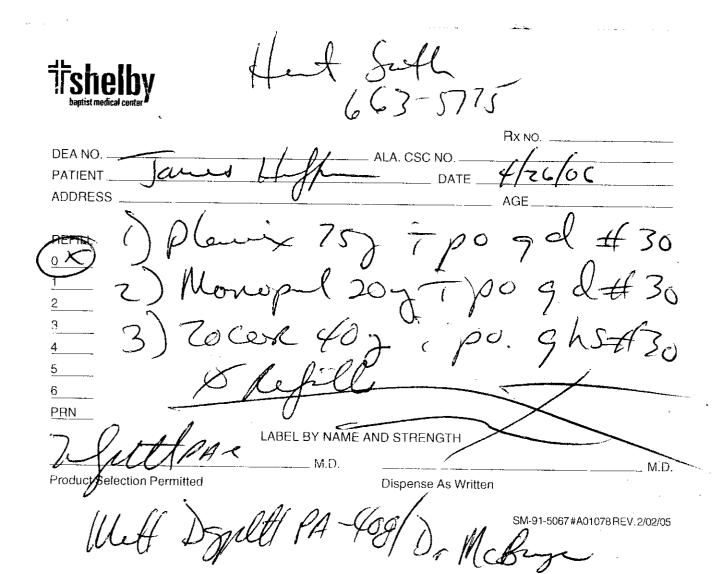


# INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 06/28/06 Pod/Location: 6 pod Cell: floor IDE	<u>‡</u>
nmate's Full Name: James Grant Huffman	
Complaint/Problem: lamexperiencing severe pain in mu	n hade nock
ind-two show the unflines I recoiled when a	1.220 - 110 1.
DOUMAN MOUNT IN Show Whom U LYN ON NOW	0400 60000
ow long have you had this problem? Since I was assaulted a	en tolatola
mate's Signature: Date:	( (
· * * * * * * * * * * * * * * * * * * *	** ******
O BE COMPLETED BY MEDICAL STAFF:	
ote Patient's Vital Signs: Temp Resp Pulse B/P	·
structions/Assessment: Document your findings, Inmate's responses/actions	
111,0	·
Received Orders – thru Treatment Protocols; via telephone order; via verbal order Follow-Up Required? If checked, date to be seen again	
nmate to be charged through medical co-pay for this visit	
Seen by Medical: Seen by:	

original form in patient's medical record.



# **PROGRESS NOTES**

DATE		NOTES SI	HOULD BE SIGNED BY PHYSICIAI	N	
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	Doctor's Si	gnature:			
NAME-Last HUHW	N James	Middle	Attending Physician	Record No.	Room/Bed

%

Page 1 of 3

□ SOUTH TEAST

☐ PRATTVILLE

286-2843 244-8448 361-4239

F0615000782 HUFFMAN, JAMES G DOB: 10/29/53 Age:52Y MR #:191817 Admit Date/Time: 05/30/06 1929P 917 SULLIVAN, JOEL C

ptist

**ER PRESCRIPTION & DISCHARGE INSTRUCTIONS** 

PRESCRIPTION FORM

Weig	pht Phone	Allergies	Tetracy	cline				Location SOUTH
MEI	DICINES PRESO	CRIBED	f non, check this bo	x: VOID IF N	IOT PRINTED \	WITH CRANBE	RRY BACK	(GROUND
Nar	ne/Strength;			Number	Schedule / Du	ration No	Refills	Refills
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4.		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
5.								
	Dante DeJesus DEA - BD 9322063 / AL 26777	DEA - AS2020066 ARN - 10094	Ronald A. Shaw DEA - BR2471326 AL - 6388	Julio Enríco Rios DEA - BR2471326 ARN - 21678	Wallace Falero DEA - AF1692119 AL - 9405	James M. Bradwel DEA - BB6422086 AL - 22767	I	
	David G. Alexander DO - 657 AA3259226	John Moorehouse DEA - AM6869119 ARN - 7151	Jessie Austin DEA - AD8394075 ABN - 8595	<b>Julian Mahaganasan</b> DEA - BM7657121 AL 24516	George Smith DEA AS2179706 AL 11413	James Thomas DEA - BT3642938 DO 374		
	Victoria L. Beckman DEA - BB6253885 AL- 22440	Carlos Gutierrez DEA - BG6616203 AL 24653	Joshua Kothue DEA - BK\$\$20724 AL 20945	James Matic DEA BM3360536 AL 17681	<b>David Hines</b> DEA BH2531160 AL 22703			
	L ALL PRESCRIPTIONS			M.D./D.O			M.D./	D.O.
No Re	eills	Product <del>8</del> €	ection Permitted	•		Dispense as Writter	n	

36 · "



FO615000782 HUFFMAN, JAMES G DOB: 10/29/53 Age:52Y MR #:191817 Admit Date/Time: 05/30/06 1929P 917 SULLIVAN, JOEL C



# ER PRESCRIPTION & DISCHARGE INSTRUCTIONS

DISC	CHARGE I	NSTRUČTIO	NS - MEDICAL CHART	1.		3 of 3		TUC HUN
Weight	Phone	Allergles			:			Location SOUTH
MEDICIN	ES PRES	CRIBED	If non, check this box:	VOID II	NOT PRINTED WITH	I CRANBE	:RAY BAC	KGROUND.
Name/Stre	ngth;	· · ·	Nur	nber	Schedule / Duration	ı N	o Refills	Refills
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2.								
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	4.	and the second s			1.			
		(		·				<u> </u>
INSTRUCTIO  ☐ Asthma ☐ Back Pain ☐ Cast/ Splin	 	Crutches Fever Fracture	☐ Head Injury ☐ Otitis Media ☐ Sprains / Bruises ☐ ST	□ <b>\</b>	hreatened Ab /omiting / Diarrhea Vound Care Other(s)	Increa Increa Increa	or signs of in sed Rednes sed Swellin sed Drainag sed Heat	ss g
Additional Ins	tructions:				g.			
	<u> </u>		Res Conf	1-17				
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		day for follow-	up appointment lext available	,lf r ph	turn to Emergency Dept in improvement or your of ysician or return to the Enterning needs assessed	ondition wor	rsens, call y epartment fo	our private or a recheck.
		•		□Ed	ucation provided on new	Medication_	MICH	riy .
Furthermore, I mo call my primar nedication or tre	any have beer y care provide atment causes	n released before r or return to this s drowsiness. I h	was rendered on an emergency bas all of my medical problems were all facility or the nearest emergency of ave read and understand the above d for modification in therapy, you will relative	pparent, diag enter. I unde e, received a	prosed, and/or treated. If my strand that I should NOT drive copy of this form and applicat	condition wors or perform ha ole instruction	ens, I have be zardous tasks	en instructed if my will arrange for
INSTRUCTED	BY:			PHYS	SICIAN:			
L XX	Mec	. Chris	il y pr			N		
WORK/SCH	OOL STATE	MENT from t	he Emergency Department					
PATIENT					DATE			
🗀 May re	turn to wo	rk/school witl	ion:days hout restrictions		☐ May return to res Restrictions:			
☐ Must b		ited by family	hool. Estimated time: // occupational physician l		Other			
Time off from school	l or work longer than	three days should be app	proved by a Personal or Company/Occupational Medi	cine Physician, un	ess otherwise stated.			

TO BE COMPLETED BY THE MEDICAL STAFF AT THE JAIL/PRISON:



Corporate Office: 3712 Ringgold Rd., #364, Chattanooga TN 37412 Phone: (423) 553-5635 Fax: (423) 553-5645

# PATIENT REFERRAL INFORMATION FORM

This patient is currently incarcerated at the jail facility listed below. Patient has been referred to your ER/facility in regarding to his symptoms/conditions listed below. All subsequent tests, procedures, and outpatient services other than requested service must be communicated and approved by the medical contact person at the jall facility to ensure justification. Failure to notify the medical contact person may result in reduced benefits and/or possible denial of payment. If hospital admission is necessary, please communicate any and all medical information as well as an estimated length of stay to our Utilization Review Department at our corporate office (423) 553-5635. Certification, justification, and/or treatment plan of continued services must be obtained to guarantee payment of the claim. Please note we have a NO NARCOTIC policy at the jail due to the uncontrolled access to medications within the facility. Please refer to our site medical staff for formulary adherence. Thank you for your cooperation in this matter.

DATE 5/30 106 PATIENT'S NAME (LAST/FIRST): HUFFMAN, James
DATE: 5/30/06 PATIENT'S NAME (LAST/FIRST): HUFFMAN, James HOUSING FACILITY/SITE: HUTAUGA METO Jail
D.O.B.: 10-29-53 SEX M F S.S.#: 418-78-9424 I.D.#: 33089
SITE PHYSICIAN: K. Nichols SITE MEDICAL CONTACT (RN/LPN): 2ina Ellis, MTA 3729
SITE MEDICAL UNIT PHONE #: 334-358-4827
REASON FOR REFERRAL: (INCLUDE HX OF ILLNESS/INJURY, PRESENT AND PAST TREATMENT WITH PATIENT RESULTS, LAB AND/OR X-RAY RESULTS, FINDINGS FROM PHYSICAL EXAM, PATIENT LIMITATIONS, ETC.):
Severe Crest pair
SERVICE REQUESTED: Eval.
TO BE COMPLETED BY THE REFERRAL STAFF AND RETURNED WITH INMATE BACK TO THE FACILITY:
FINDINGS: Womal LXG + 1 cels
PLANNED TREATMENT: Ret for follow, - Needs  ER/HOSPITAL PHYSICIAN ORDERS:  # follow with
ER/HOSPITAL PHYSICIAN ORDERS:
ER/HOSPITAL CONTACT (INCLUDE PHONE NUMBER): BMC Pre Hyll  361-4234
NOTE(S):
DEA AS2020066
PLEASE RETURN THIS FORM WITH THE CORRECTIONAL STAFF UPON DISCHARGE OF THE PATIENT OR FAX
DIRECTLY TO THE SITE FAX NO. NOTED ABOVE. IF INPATIENT HOSPITALIZATION IS REQUIRED, MEDICAL STAFF
MUST BE NOTIFIED IMMEDIATELY. THANK YOU.

☐ south

286-2843

⊒ EAST

244-8448

PRATTVILLE

361-4239

#### RESCRIPTION: FORM





B0611900267 HUFFMAN, JAMES G DOB: 10/29/53 Age:52Y MR #:319167 Admit Date/Time: 04/29/06 915 FALERO, WALLACE G 1755P

BSB-0082 (06/02)

Weight Phone	Allergies					Location South
MEDICINES PRES	SCRIBED II	non, check this box:	VOID IF NO	OT PRINTED WIT	H CRANBERRY B	ACKGROUND.
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Emilio Belaval At 22654 DEA - 885285248	Joet Sullivan DEA - AS2020066 ARN - 10094	Ronald A. Shaw AL - 6388 DEA - AS5646813	Julio Enrico Rios ARN - 21678 DEA: BR2471826	Wallace Falero AL 9405 DEA AF1652119	James M. Bradwell DEA - BB6422086 AL - 22767	
David'G: Alexander DO -657 AA3259226 Victoria L. Beckman DEA - 8862533635 AL -22440	John Moorehouse DEA: AM8869113 ARN: 7151 Steven G. O'Mera DEA: B01736074 DO - 713	Jessie Austin DEA - AA8394075 ARN - 8595 Brad Frisble DEA - BF2524583 ARN - 15996	Tom Decard DEA - AD2628355 ARN - 11369 Thomas Amold DEA - A49548655 ARN - 16275	Henry Kurusz III: DEA - AK2572116 AL - 22198  Paul Tanaka ARN - 7153 DEA - 8922-898	0900 A HINES OHRS31166 22703	
Label all prescriptions No refills		OAA— election Permitted	M/ D;7D;O.			M.D./D.O.

-// H E /	THERN ALTH D.O.B. or I.D. #: 10/09/53
Start at top and write subse	Allernies: 1/1/2 A
Date of physician's order:	
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00 65 00 65	Hen Start
8/1/8	H. A. D. estine 20mg it sales a.H.
Data of physician's audom	parviois. Michaes / Cooking
Date of physician's order:	DC Plaux 75mg
11/9/05	AsA 325mg po b.d.
er a	vo Dr Nichald/ & Car
	N 9
Date of physician's order:	Continue meds as taken:
	mevacor 40 mg = po daily
5/2/04	Dasotec 20mg = po bid
	Vistoril 25mg - po bid.
	Prozac 20mg in po g pm.
Date of physician's order:	Elavil 100 mg + po g pm.
	ASA 325mg 7 po bid.
A.	UU Or Nichala/ 2 Com
	N/2
Date of physician's order:	Tylenol 325mg is po bid x 7 days
c .06	7PO Dr Nichols/ Bloch
5,5,06	Mis
Date of physician's order:	
	Tylenol 305mg = tops bid x 3days.
5/24/06.	TROP DE Mechalo. Ht Morla (AN)
	Ny

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NAME	Toas	Hulfman		Document 17-4	Filed 10/10/2006  DATE OF BIRTH	Page 27 of 5	
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Corporate Office: 3712 Ringgold Rd., #364, Chattanooga, TN, 37412

Phone: (423) 553-5635 Fax: (423) 553-5645

### PATIENT REFERRAL INFORMATION FORM

patient is currently incarcerated at the jail facility listed below. Patient has been referred to your ER/Facility regarding his/her spendions or rtions listed below. All subsequent tests, procedures, and outpatient services other than requested service must be communicated and oved by the medical contact person at the jait facility to ensure justification. Failure to notify the medical contact person may result in ced benefits and/or possible denial of payment. If hospital admission is necessary, please communicate any and all medical information as as an estimated length of stey to our Utilization Review Department at our corporate office at the # listed above. Certification, justification, or treatment plan of continued services must be obtained to guarantee payment of the claim. Please, note we have a NO NARCOTIC policy jail due to the uncontrolled access to medications within the facility. Please, refer to our site medical staff for formulary adherence. Thank or your cooperation in this matter. BE COMPLETED BY THE MEDICAL STAFF AT THE JAILPRISON: Patient's Name (Last/First): Hattman, James Inmate Loc: 3 using Facility/Site: Hutauga Metro Appt. Destination: DeNtist ot. Address & Phone #: Medical Contact (RN/LPN): TINA Ellis, MTA Site Physician: Dr. **Le Me**dical Unit Phone #: 334-358-3729 Site Medical Unit Fax #: 334-358 - 4827 son For Referral: (Include Hx of itiness/injury, present and measurement with patient results, lab and/or x-refindings from physical exam, patient limitations, allergies, and reions, etc.) vice Requested: EVAL./TX BE COMPLETED BY THE REFERRAL STAFF AND RETURNED WITH INMATE BACK TO THE FACILITY: Hospital Physician Orders:

ase, return this form with the correctional staff upon discharge of the patient or fax directly to the site fax # ed above. If inputient hospitalization is required, medical stuff MUST be notified immediately.

Notes:

/Hospital Contact (Include Phone #):

porization for payment of services is only guaranteed during the time of actual confinement of the immate under the custody of the above d jail/prison and under the terms of our County contract.

Case 2:06-cv-00748-MEF-WC Document 17-4 Filed 10/10/2006 Page 29 of 57 PROGRESS NOTES

Last Name	First Name Attending Physician Room No. Hosp. No.
Date	Notes: Should Be Signed by Physicians 1997 A 1997 A 1997
5/3/0	I'm brilliaght up to realized.
7/104	Jos do Ot S.D.B. R. 20 P. 85
	BP 112/74. Ilm has not 40 04
	which to clock stated to recorded
	Out a como to Cotch lims. Il
	and to thinks that is what remade
	his clost sow. put I/m up in also
	for montoring for a hour or two.
	Will monitoe. O A. Honly Pr
6/3/06	I/m came to Med room claiming his chest was
	husting + had a heaviness feeling a chest. If m
<b>&amp;</b>	stated pain was radiating down (Darm I was
	having thouse breathing. Checked I'm's VS -
	BP 14/20 P102, gave one initro-quick under torque, waited
	5 minutes 1 15 again BP 1/34 P-107, I'm stated he
	was still huiting, give anothe 2nd Nitro-guick,
	VVS 3rd time BP 19/12 P-127, called D1. Nichols & Re gave TO to send to E.R. You eval, talket & D. Ellis, Mr.
	gave 10 la pena w C.K. for eval, Earlest & S. Ellis, Mr.



# INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be this facility.

Today's Date: 210 5 Pod/Location: 40 Cell: 403 ID# 29089
Inmate's Full Name: James 6, Huffman
Complaint/Problem: My Cardiologistie. Doctor Fine
told me after my heart Surgery Stat T
Meded to Sake Pavik every day of the w www. I taken of State Tope of the w How long have you had this problem?
Inmate's Signature: Date: 12/10/05
TO BE COMPLETED BY MEDICAL STAFF:
Note Patient's Vital Signs: Temp 97.9 Resp 18 Pulse 93 B/P 118/ )7
nstructions/Assessment: Document your findings, Inmate's responses/actions
In Meds being taken. Advised I/m To have
on meds being taken. Advised I/m To have Plavix brought from Home. To take own meds.
Received Orders – thru Treatment Protocols; via telephone order; via verbal order Follow-Up Required? If checked, date to be seen again
te Seen by Medical: (2/16/05 Seen by: 2
ce original form in patient's medical moord



# INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be this facility.

Today's Date: 05/17/06 Pod/Location: D-3 Cell: ID#
Inmate's Full Name: JAMES G. HUFFMAN
Complaint/Problem: AM STILL HIPTING PEAL RAD II LAND
X SIN WHERE I WAS ALLOT DU TUE GUAGASTIL
OVER PURING MY HEART CATH IT BURNS AS WELL
PURING MY HEART CATH IT BURNS AS WELL How long have you had this problem? SINCE SURGERY ON 04/28/06!  Inmate's Signature: American Grant General Control of the signature of the surgery on 04/28/06!
Date: 05/17/06
TO BE COMPLETED BY MEDICAL STAFF:
Note Patient's Vital Signs: Temp 976 Resp 30 Pulse 92 B/P 126/71
Document vour findings Inmed-
water aisses ( This time of 1)
evaluate Added h mp lest - Moul
Nace gentry - Dr Maline
So this wire he a follow up
<ul> <li>☐ Received Orders — thru Treatment Protocols; via telephone order; via verbal order</li> <li>☐ Follow-Up Required? If checked, date to be seen again</li> </ul>
☐ Inmate to be charged through medical co-pay for this visit
Date Seen by Medical: 5/19/06 Seen by: M. Oah
Place original form in patient's medical record.

Case 2:06-cv-00748-MEF-WQ Document 1774 SFiled 10/10/2006 NPage 3/20 57

NEVER HAD THE PROBLEMS I MM HAVING NOW, I'M IN SEVERE PAIN, AND NEED TO BE EITHER X-RAYED OR HAVE AN ULTRASOUND DONE ON ME BECAUSE SOMETHING IS TERRIBLY WRONG! PLEASE HELP ME.

Thank you, James & Huffman



### **Blood Pressure Record Form**

Inmate's Name: Huffman, JAMES	D.O.B.: 10/29/53,
Orders/Instructions: BP / g wk.	Have M.D. review findings upon visit
Physician:	Administrator:

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DATE	B.P.	ARM	INITIAL
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11/19/5	152/91		a
11/210	Bedi	see	
12-16-05	118/440	11+	AH
1/8/06	140/82	L+	pr.
4/6/06	138/84	4	n-
1/24/04	140/82	U	n
1/27/14	137/76	U	n
2/6/04	139/80	G	p
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### INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 05-10-06 Pod/Location: 0-3 Cell: ID#
Inmate's Full Name: JAMES GRANT HUFFMAN
Complaint/Problem: I have an abcused tooth, a molar, on
the right bottom jaw that is very swollen and
has puss in and around it. a need something
How long have you had this problem? I for about 2 augs.
Inmate's Signature: Date: 05/10/06
******* ** ** ** ** ** ** ** ** ** ** *
TO BE COMPLETED BY MEDICAL STAFF:
Note Patient's Vital Signs: Temp 98 Resp 20 Pulse 7/ B/P 35/83
instructions/Assessment: Document your findings, Inmate's responses/actions Alocco (F) L molor
Reflex 500mg ii BID X 7 days Parrogenii BID x 7 dap per ty
protocal. Added to hental list - M. Oak Kn
Received Orders - thru Trootmont Protocology in talland
Received Orders – thru Treatment Protocols; via telephone order; via verbal order  Follow-Up Required? If checked, date to be seen again
Inmate to be charged through medical co-pay for this visit
ate Seen by Medical 10/06 Seen by: M. Oal M

ace original form in patient's medical record.

Document 17-4

Filed 10/10/2006

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#### **MEDICAL HISTORY & PHYSICAL ASSESSMENT**

glasses	Problems	Yes	No	Problems	Yes	No	Problems	Yes	No
3143	Vision	V		Hypertension		-	Gonorrhea		1
~	Hearing		V	Anemia		V	Syphilis		
	Balance/Dizziness			Blood		-	Muscle Problem		
	Blackouts		ر ا	Stomach Pain		V	Joint Problem	1	
	DT's		V	Heartburn		V	Arthritis		
	Headaches			Ulcer		L	Other	'	
	Seizures			Nausea/Vomiting		2	Other		
	Nervous Disorder		1	Gall Bladder		~	Regular Menstrual Period		
3 40~	Throat	1500	-	Liver		1	Irregular Menstrual Period		
BOHOM .	Teeth	ī	,	Hepatitis		i	# of days Menstrual Period		
10111	Asthma		V	Diabetes		L	LMP		(40)
	Hay Fever			Kidney Disease		1/	Gravida/Para		774.
	Pneumonia		V	Bladder Infection		-	Last Pap	1-1-	
mat.	Tuberculosis		V	Trouble Voiding			Contraception		
05-	Heart	L		Pediculi (lice)	1	1	Other		

EXAM:

Age 52 Sex  $\underline{m}$  Race  $\underline{\omega}$  Ht.  $\underline{\omega}''$   $\underline{0}''$  Wt.  $\underline{165}$ 

Temp.982 Pulse 7 Resp. / 8 Area/Type A/Comment Area/Type A/Comment Skin: Color Chest (Breasts): Condition Configuration normal Turgor DOMA Auscultation Recent Inj. Respirations Cough/Sputum Head: Glasses Heart: Auscultation Pupils Radial pulses Sclera normal Apical pulse Conjunctiva Rhythm Vision Ears: Appearance Extremities: Pulses Canals Edema Hearing Joints Mouth: Teeth/Gums normal Abdomen: **Dentures** Shape **Plates** Throat Palpation Tongue Hernia Tonsils Bowel Sounds NOV MAY Nose Spine DOMAI Neck: Veins Genital/Urinary Mobility System normal nomed. Thyroid Carotids Lymph nodes

LABORATORY TESTS

	Date & Initial	Results
Was PPD planted and read timely?	1/3/00.	4
VDRL/RPR		
Other Lab Tests needed:		
Pregnancy Test?		

#### **MENTAL HEALTH OBSERVATION**

	N	A/Comment
Orientation (person, place, time)		normal
General appearance (motor behavior, mannerisms		normal
Affect (mood)		Normal
Content of thought, history of suicide, present thoughts of suicide		normal.

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Physician's Signature:

A. Monly upo.

### Tuberculosis Screening and Treatment

#### What is Tuberculosis:

Tuberculosis ("TB") is a serious, infectious (transmitted through the air) disease that most commonly affects the lungs. In the lungs, the bacteria destroys elastic lung tissues and is replaced with fibrous connective tissues. The general symptoms of active TB are often subtle, unnoticeable and may include: Fatigue; Weight Loss; Fever; Chills; and Night Sweats. Symptoms of TB in the lungs may include: a persistent cough; chest pain; and coughing up blood. Although TB is preventable and can be cured with proper medication, 5% to 10% of those with active TB will die from the disease. This is usually due to patients not taking their medications correctly or improper drug treatment. TB is usually diagnosed through the use of the Mantoux tuberculin skin test. In this test, a dose of purified protein derived from the Tubercle bacilli, which is non-infectious, is injected into the upper layer of skin on the inside of the forearm. Forty-eight to 72 hours after the injection, the test site is examined. In most cases a hardened area of tissue 10 millimeters or larger is considered an indication of infection with TB, but it is not necessarily an indication of having active TB. Chest x-rays and sputum smears and cultures are used to test for active TB.

There are several high risk groups in the US that are known to have a high rate of TB. They include:

- The homeless;
- IV drug users

Alcoholics:

Prison inmates

- The elderly:
- Persons with HIV infections/AIDS

#### Screening:

Upon consent, all new inmates who are processed into jail, without written proof of receiving TB testing in the past year, will receive purified protein derivative (PPD) during the health screening. A nurse will read the PPD forty-eight (48) to seventy-two (72) hours afterwards and document the results in the patient's medical file. The patient will be instructed during the health screening to the necessity of follow-up medical care, the results (both positive or negative) and treatment which may be necessary.

#### Treatment:

During the screening, if a patient states he/she is past positive, we will not plant PPD, but will obtain a chest xray to see if the tuberculosis is active. When a nurse reads a positive PPD, a chest x-ray will be ordered as per physician protocol. The patient will receive information regarding the test results, symptoms of TB, proposed treatment, and follow-up care, etc.

Should the chest x-ray suggest active TB, the local Health Department, SHP Medical Team Administrator, and SHP corporate office should be notified immediately. Initiating therapy/treatment should begin under the recommendations of the local Health Department and in conjunction with the jail physician. The jail will immediately segregate the patient from general population. All people who have come in contact with the patient will have a skin test. The patient will have restricted movement and visitors in the jail, and will be required to wear a mask at all times during contact with staff and/or other persons, until subsequent tests prove no longer infectious.

All new inmates who are processed into the jail, who are on treatment and deemed not infectious will be housed in general population. If a patient is released from Jail during therapy, the local Health Department will be notified and provided with the patient's release location and/or the patient's last known address.

#### Consent for Testing/Treatment:

I hereby give my consent for TB testing and/or treatment, if needed. I have read and understand the above information regarding testing and treatment procedures.

Signature

Witness

confidential Medical Information

LAST NAME TIME AM/PM	MIDDLE	Southern Heal	SCREENING	
PREVIOUS INCARCERATIONS:				
PREVIOUS INCARCERATIONS:	SEX	SOCIAL SECURITY NO.	DOB	
CURRENT INSURANCE COVERAGES?		418-78-9424	101	29/5-
BC/BS	CURRENTLY UNDER PHYSICL	AN'S CARE FOR CHRONIC CONDITION:		7
VISUAL / MEDICAL OBSERVATION: (Explain all "Ye	as" Answers) Circle V	or Mi	VEO	
is infrible unconscious of showing visible signs of illness, in	jury, bleeding, pain, or ot	her symptoms suggesting the	YES	NO (N.)
If yes:				
Are there any visible signs of fever, jaundice, skin lesions, ramarks, body vermin?  If yes:	ash, or infection: cuts, bro	uises, or minor injuries; needle	Ø	N
Does the inmate exhibit any signs that suggest the risk of sulf yes:	icide, assault, or abnorm	al behavior?	Y	(N)
Does the inmate appear to be under the influence of, or with if yes:	drawing from drugs or al	cohol?	Y	(N)
Is the inmate's mobility restricted in any way due to deformit If yes:	y, cast, injury, etc.		Y	N
ASK THE INMATE THESE QUESTIONS: (Explain all	"Yes" answers)			
Have you had or been treated for: (circle as appropriate) as pressure, mental health problems, seizures, ulcers, or other Other:	thma dishetes eniloney	, <u>heart condition</u> , <u>high blood</u>	(1)	N
Have you taken or are you taking any medication(s) prescrib If yes:	ed for you by a physician	?	0	N
Are you allergic to any medications, foods, plants, etc.? If yes:			(1)	N
Have you tainted or had a head injury within the last 72 hours If yes:	\$?		Y	N
Do you have or have you been exposed to AIDS, hepatitis, Ti f yes:		cable disease?	Y	N
Have you been hospitalized by a physician or psychiatrist with fives: Birming head to have you ever considered or attempted suicide?	hin the last year?		(1)	N
ryes:			Y	(2)
Do you have a painful dental condition? f yes:			Y	N
Are you on a specific diet prescribed by a physician? fyes:			Y	N)
o you use drugs? How often? Vhat kind?	Last time? How much?		Υ	N
o you use alcohol? How often? Vhat kind?	Last time? How much?		Y	N
emales: LMP Date: re you pregnant, recently delivered or aborted; on birth contr	ol pills; having abdomina	I pain or discharge?	Yiv	AN
yes: IOTE VITAL SIGNS:				
	emperature: 98-6	. Blood Pressure: 10	1 C / C	
	-		17/5	1
AVE ALL CONCERNS FROM OFFICER INTAKE FORM BE RE ALL STATED CHRONIC CONDITIONS NOTED:		INMATE? Yes-		<u> </u>
PD IMPLANTED? Y OR N ARM LOCATION: R		TERLIFER FOR ALPHANA	<u> </u>	<del></del>
EMARKS: Bruising bilateral grain		HEDULED FOR 14 DAYS: 1/3/01	¥ 0.	
From Heart Klath.				
ave answered all questions truthfully. I have been told and shown hease. I hereby give my consent for professional services tolbe grove	ow to obtain medical service ided to me by and through S	es and advised on how to obtain m Couthern Health Partners, Inc.	edication u	pon
nate's Signature:	$\omega \sim$	Date:	5-1-	06
erviewer's Signature and Title: 22 Ca		Date:	<u> </u>	<del></del>

MEDICATION: ADMINISTRATION FILE COUNTY JAIL Filed 10/10/2006 FFM DATE: 08/06

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9	10 11 12 13 14 15 16 17 18 19 20 21 22 23 2	4 25 26 27 28 29 30 31
LOVASTATIN 40 MG TABLET	05/08/03		
MEVACOR 40 MG TABLET	0000 1 2 3 4 5 6 7 8 9	10 11 12 13 14 15 16 17 18 19 23 21 22 23 2	4 25 26 27 28 29 30 31
TAKE 1 TABLET ONCE DAILY	123456780	10 11 12 13 14 15 16 17 18 19 29 21 22 23 2	C 32 32 32 32 38 38 80 81
0,0	1 2 3 4 5 6 7 8 9	10 11 12 13 14 15 16 17 18 19 20 21 22 23 2	4 25 26 27 28 29 30 31
ENALAPRIL MALEATE 20 MG		10 11 12 10 14 10 14 17 10 13 24 21 22 23 2	4 25 26 27 28 29 30 31
VASOTEC 20 MG TABLET	-nann 1 2 3 4 5 6 7 8 9	10 11 12 13 14 15 16 17 18 19 20 21 22 23 2	4 25 26 27 28 29 30 31
TAKE 1 TABLET TWICE DAILS	10an 11181 4 10 8 8 8 8 8 1	HOLD THE BOOKENESS OF THE STATE AND A STATE OF THE STATE	10 10 10 10 26 23 MM AD
DIC	T7000 2 3 4 2 P 7 8 9	[10]11  12 13 14 15 16 17 18 19 20 21 22 23 2	4 25 26 27 28 29 30 31
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DAILY	<del>1700</del> 1 2 3 4 5 6 7 8 9	10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	1 25 26 27 28 29 30 31
FLUOXETINE 20 MG CAPSULE		AND SCIENTIA POR CONTRACTOR AND SCIENTIAN SCIE	THE TOTAL PROPERTY.
PROZAC 20 MG PULVILLE	05/08/07	10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	135 36 37 30 30 30 34
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HUFFMAN, JAMES	10/29/19 <b>\$</b> 3 M	Code HUFFJAME	Date 00/00/00

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### MEDICAL INFORMATION TRANSFER FORM Confidential Medical Data

To:	From: Medical Unit auga Metro Jall
,	DOB: S.S.#: 418-78-9424
MEDICAL PROBLEMS: HTM, D.	epression, Anxiety
TREATMENTS/MEDICATIONS: Prozac 20 mg bid Vistaril 25 9 cm, Lovantation 40 mg	g Am ASA 325 mg bid
PREGNANT: Yes No Unknown	TB SKIN TEST: (Neg) Pos Date: 1/5/04
OTHER LAB DATA:  TESTED: Treated  RPR: Neg Pos Yes No VDRL: Neg Pos Yes No GC: Neg Pos Yes No Other: Yes No	Date  Date
PERSON COMPLETING FORM:	n m TA
Printed Name: <u>Gail Colbura</u>	m 7A Date: 2/6/06
Our Phone Number 334-358-372	5

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### TROPONING ### TROPONING ### TROPONING ### TROPONING ### TROPONING ### MYOGLOBIN B ### MYOG	### TROPONIN  ### MYOGLOBIN B  ### MYOGL	4 CPKMB	0	13733	0	255	r (	2.0	62.0	
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5 CVS INTRO EXTREMITY       71671051 361 36140       1       279.00       279.00       426.00       426.00       426.00       426.00       426.00       426.00       426.00       426.00       426.00       426.00       426.00       1932.0	5 CVS INTRO EXTREMITY       71671051 361 36140       1 279.00       279.00         6 US PSEUDOANEURYSM       66307505 402 76936       1 426.00       426.00         2 ER FEE-CLASS VI CRIT       05105002 450 99291       1 1932.00       1932.0         5 LEFT HEART CATH PERC       71109003 481 93543       1 5216.00       5490.0         5 LV/LA GRAM       71110308 481 93543       1 5490.0       5490.0         5 CORONARY ANGIOGRAM S       71110506 481 93545       1 5490.0       5698.0         5 CVS HEART CATH       71671325 481 93555       1 1277.0       1277.0         5 CVS HEART CATH       71671333 481 93556       1 1277.0       1277.0         5 CVS HEART CATH       71671334 481 93556       1 10.0       16.0         5 CVS ISOVUE 370 PER M       71677926 255 09950       75 10.0       10.0         5 CVS VISIPAQUE 320 PER M       71677934 255 09949 110       1.00       1.00         2 EKG 12 LEAD       87110540 250 72405 4       4 48.00       1.54.0         3 of 5       1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2 ER PROCEDURE LEVEL	O un	10603	A A	<b>T</b> 0 T	-€ ٢	200	0 C	
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2 ER FEE-CLASS VI CRIT       05105002 450 99291       1 1932.00       1932.0         5 LEFT HEART CATH PERC       71109003 481 93510       1 5216.00       5216.0         5 LV/LA GRAM       71110308 481 93543       1 5490.0       5490.0         5 CORONARY ANGIOGRAM S       71110506 481 93545       1 5698.0       5698.0         5 CVS HEART CATH       71671325 481 93556       1 1277.0       1277.0         5 PULMON/AORTO/ANGIO/B       71671333 481 93556       1 1277.0       1277.0         6 LVS HEART CATH       71671333 481 93556       1 1277.0       1277.0         7 INJECT INTRAVENOUS       71677926 255 09950       75 1100       16.0         5 CVS ISOVUE 370 PER M       71677934 255 09950       75 1100       170.0         5 CVS VISIPAQUE 320 PE       87110540 255 09949 110       1.00       192.0         7 EKG 12 LEAD       93005 2       77.00       154.0	Z ER FEE-CLASS VI CRIT  5 LEFT HEART CATH PERC  5 LEFT HEART CATH PERC  71109003 481 93510 1 5216.00 5216.0  5 LV/LA GRAM  5 LV/LA GRAM  5 CORONARY ANGIOGRAM S  71110506 481 93543 1 5490.00 5490.0  71110506 481 93545 1 5490.00 5698.0  71110506 481 93555 1 1277.00 1277.00  71671325 481 93556 1 1277.00 1277.00  71671333 481 93556 1 1277.00 1277.00  7167733 940 C8952 1 16.00 1277.00  71677926 255 09950 75 1.00 110.00  71677934 255 09950 75 1.00 110.00  71677934 255 09949 110 1.00 110.00  71677934 255 09949 110 1.00 1192.00  7 EKG 12 LEAD 05130026 730 93005 2 77.00 154.00	6 US PSEUDOANEURYS	9	30750	0	693	<del>,  </del>	26.0	26.0	
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5 CORONARY ANGIOGRAM S 71110506 481 93545 1 5698.00 5698.0 5 CVS HEART CATH 71671325 481 93555 1 1277.00 1277.0 2 INJECT INTRAVENOUS 05130273 940 C8952 1 16.00 16.0 5 CVS ISOVUE 370 PER M 71677926 255 Q9950 75 1.00 170.0 5 CVS VISIPAQUE 320 PE 71677934 255 Q9949 110 1.00 110.0 7 CVS VISIPAQUE 320 PE 87110540 250 J2405 4 48.00 1192.0 7 CKG 12 LEAD 05130026 730 93005 2 77.00 154.0	5 CORONARY ANGIOGRAM S 71110506 481 93545 1 5698.00 5698.0 5 CVS HEART CATH 71671325 481 93555 1 1277.00 1277.0 5 PULMON/AORTO/ANGIO/B 71671333 481 93556 1 1277.00 1277.0 2 INJECT INTRAVENOUS 05130273 940 C8952 1 16.00 16.0 5 CVS ISOVUE 370 PER M 71677926 255 09950 75 1.00 175.0 5 CVS VISIPAQUE 320 PE 71677934 255 09949 110 1.00 192.0 7 CVS VISIPAQUE 320 PE 87110540 250 J2405 4 48.00 192.0 7 CVS VISIPAQUE 320 PE 87110540 250 J2405 4 48.00 154.00	5 LV/LA GRA	두여	11030	8	354	ed	490.0	490.0	
5 CVS HEART CATH 71671325 481 93555 1 1277.00 1277.0 5 PULMON/AORTO/ANGIO/B 71671333 481 93556 1 1277.00 1277.0 2 INJECT INTRAVENOUS 5 CVS ISOVUE 370 PER M 71677926 255 09950 75 1.00 175.0 5 CVS VISIPAQUE 320 PE 71677934 255 09949 110 1.00 110.0 7 CVS VISIPAQUE 320 PE 87110540 250 J2405 4 48.00 192.0 7 CKS ISOVUE 370 PE 87110540 250 J2405 4 48.00 154.0	5 CVS HEART CATH 71671325 481 93555 1 1277.00 1277.0 5 PULMON/AORTO/ANGIO/B 71671333 481 93556 1 1277.00 1277.0 2 INJECT INTRAVENOUS 5 CVS ISOVUE 370 PER M 71677926 255 09950 75 1.00 16.0 5 CVS VISIPAQUE 320 PE 71677934 255 09949 110 1.00 110.0 2 CNDANSETRON 1MG/0.5% 87110540 250 J2405 4 48.00 154.0 2 EKG 12 LEAD 05130026 730 93005 2 77.00 154.0	5 CORONARY ANGIOGRAM		11050	œ	354	, <b>†</b>	698.0	698.0	
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2 INJECT INTRAVENOUS       05130273 940 C8952 1 16.00         5 CVS ISOVUE 370 PER M       71677926 255 Q9950 75 1.00         5 CVS ISOVUE 320 PE       71677934 255 Q9949 110 1.00         2 ONDANSETRON 1MG/0.5M       87110540 250 J2405 4 48.00         2 EKG 12 LEAD	2 INJECT INTRAVENOUS 05130273 940 C8952 1 16.00 16.00 5 CVS ISOVUE 370 PER M 71677926 255 Q9950 75 1.00 75.0 75.0 2 CVS USIPAQUE 320 PE 71677934 255 Q9949 110 1.00 110.00 2 CVS VISIPAQUE 320 PE 87110540 250 J2405 4 48.00 192.00 192.00 2 EKG 12 LEAD 05130026 730 93005 2 77.00 154.0	5 PULMON/AORTO/ANGIO/	-	67133	æ	3.5 5.5	rd	277.0	277.0	
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Case 2:06-cv-00748-MEF-WC	Document 17-4	TOENT PRO FEE  (20) TELEMETRY (10) TELEMETRY	PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME	elby HUFFMAN, JAMES G Encounter #571 -BPAOCY3 NAL BILL DATE FROM P50 04/30/06 04/23 04
		N SERVICE REV CP 05130042 730 93 23200058 730 93 23200058 730 93 23200058 730 93 23200058 730 93 66312000 921 93	PAT NJMBER ROOM 57129694 244 - B	129694 4/23/2006 DETAIL ITEMIZED BILLS 4/3 BAP MED CNTR-SHELBY TO P.O. BOX 11407 4/27 BIRMINGHAM, AL 205 592-1216
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nelby HUFFMAN, JAMES G Encounter #57129694 S-RDACCY3	4/23/2006 DETAKL ITEN BAP ME	ITEMIZED BILLS 4/30/2006 MED CNTR-SHELBY	2006 LBY	RPT ID:
) 4( ,	P.O. B BIRMIN 205 59	OX 11407 GHAM, AL 2-1216		
PATIENT NAME PHUFFMAN, JAMES G	PAT NUMBER 57129694	ROOM 244 - B	ADMITTED DISCHARGED 04/23/06	РАGE 5
£	INSURANCE	CO. P	LAN POLICY/GROUP	FIN CLASS
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ALABASTER AL 35007			!	
DATE DESCRIPTION PATIENT PRO FEE	ស ሟ	VICE REV	CPT-4 QTY PRICE	TOTAL
MARY OF CH M-BOARD/SE	TOTAL 120		PATIENT	
4 DAYS @ 770		0.080	0.080,	
HARMAC	50 1	471.0	471.0	
ED-SUR SUPPL	-	40.0	40.0	
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THER RX SVS	4	16.0	16.0	
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<b>たら/ほこら</b> 野め子 なみのクロュー	90	0.50	0.62	
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SUB-TOTAL OF CHARGES	33,	760.00	33,760.00	
TOTALS	33,	,760.00	33,760.00	! :
page 5 of 5				PAY THIS

## BAPTIST HEAST 196-CY-00748-MICE-WCCOUNTON MAY BE SENT TO OUR COLLECTION AGENCY ACCOUNT MAY BE SENT TO OUR COLLECTION AGENCY

#### ►ACCOUNT SUMMARY

Patient Name: HUFFMAN , JAMES G

Account Number: 57129694

Service Date(s): 04/23/06 - 04/27/06

Attending Physician: TURNER, DR. MICHAEL JAMES

Statement Date: 07/04/06

Total Charges: 33,760.00

Insurance Payments: 0.00

Patient Payments: 0.00

Adjustments: 0.00

Current Account Balance: 33,760.00

Current Patient Balance Due: \$33,760.00

#### ►INSURANCE INFORMATION

Primary: SG SHELBY MUN

#### ► MESSAGES

Baptist Health System is committed to its mission of providing emergency healthcare to all who need it regardless of ability to pay. If you believe you might qualify for financial assistance on this and/or other Baptist Health System bills, please call 205-592-1216 or 800-443-1039. We will explain the evaluation process and forward the appropriate forms that are necessary for your consideration of financial assistance. Thank You.

If your check is returned for non-sufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

**►**MENSAJES

El Baptist Health System está dedicado a su misión de ofrecer cuidado de la salud de emergencia a todas las personas, sin importar su capacidad de poder pagar. Si piensa que podría ser elegible para recibir ayuda financiera en estas facturas y/u otras facturas del Baptist Health System, por favor llame al 205-592-1216. Le explicaremos el proceso de evaluación y le enviaremos los formularios apropiados necesarios para que se le considere para recibir ayuda financiera. Muchas gracias.

Si se devuelve su cheque por falta de fondos, usted autoriza expresamente que su cuenta se cargue electrónicamente o que se ejecute un giro bancario por el monto del cheque además de las tarifas aplicables. El uso de un cheque para el pago es su confirmación y aceptación de esta política y de sus términos y condiciones.

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

DISCOVER TELEVISION

#### 

VISA

BAPTIST
HEALTH SYSTEM
P.O. BOX 11407
BIRMINGHAM, AL 35246-0145

33083\*1UC0CSQK3000700

#### RETURN SERVICE REQUESTED

STATEMENT DATE: 07/04/06

PRATTVILLE, AL 36067-3002

0101

Please check box if below address is incorrect or insurance information has changed, and indicate change(s) on reverse side

Infinitellation and Addresses:

JAMES G HUFFMAN

136 N COURT STREET

ACCOUNT NUMBER AMOUNT DUE 57129694 \$33.760.00

MASTERCARD

CARD NUMBER

SIGNATURE

07/19/06

AMOUNT PAYING

EXP DATE

SECURITY CODE

AMERICAN EXPRESS

522737B

REMIT TO:
Inflation deliberation of the second seco

CY # 418789424 GP: CP:	CARD NUMBER	VISA	AMOUNT	
	NAME ON CARD		EXP. DATE	
	STATEMENT DATE 07/07/2006	PAY THIS AM	434.00	ACCT. #
YOUR INSURANCE, POLICY NUMBER, GROUP NUMBER OR -PAY HAVE CHANGED - PLEASE CORRECT ON THE REMIT SLIP. ANK YOU. ADDRESSEE	TAX I.D.	PAID I		<b>\$</b>
JAMES G. HUFFMAN 136 N COURT STREET PRATTVILLE, AL 36067	CALERA FAMILY HE PO BOX 1450 CALERA, AL 35040-			

DATE			DESCRIPTION			CHARGES	INSURANCE	PATIENT
04/23/2006 04/24/2008 04/25/2006 04/26/2006 04/27/2006	992238 99232 99232 99232 99238	SUBSEQ HOSP SUBSEQ HOSP SUBSEQ HOSP	MISSION, COMPREH CARE-COMPLEX - I CARE-COMPLEX - I CARE-COMPLEX - I RGE 30 OR LESS - M	MICHAEL J TURN MICHAEL J TURN MICHAEL J TURN	ER, MD ER, MD ER, MD	\$172.00 ; \$62.00 \$62.00 \$62.00 \$76.00		\$172.00 \$62.00 \$62.00 \$62.00 \$76.00
				OUDERALT	20 DAYS	60 DAYS	90 DAYS+	BALANCE DU
ACCOUNT N		COUNT TOTAL	INS. PENDING	CURRENT	30 DAYS	CIALLOO	1 30 00 10 1	_,

NOTES:115
WE ARE REQUIRED BY YOUR INSURANCE COMPANY TO COLLECT ALL CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE AT TIME OF SERVICE. PRIVATE PAY PATIENTS ARE REQUIRED TO PAY AT TIME OF SERVICE.

CALERA FAMILY HEALTH, PC PO BOX 1450 CALERA, AL 35040-\_\_\_ (205)868-0941\_\_